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ABSTRACT

Most studies investigating the decision to seek mental health care have focused on socio-demographic differences in health utilization behavior rather than psychological variables. To evaluate three psychological explanations of help-seeking behavior, i.e., the health belief model, the socio-cultural perspective, and an ego psychological approach, a national survey of 2,264 adults, representative of the American population on major socio-demographic characteristics, were interviewed in depth about their sense of well-being and their help-seeking behavior. The data were coded into over 50 independent variables representing five conceptually distinct psychological categories, i.e., distress, intrapsychic measures, help-seeking variables, resources, and values. Analysis of results showed that the health belief model seemed to account best for the decision to seek formal help, based on perceived impaired functioning. Seeking mental health care rather than other kinds of formal help was best predicted by the social network factors of the socio-cultural perspective, suggesting that situational factors, particularly those related to the help-seeking process, play a much more important role than enduring, internalized dispositions and reported distress. Multivariate psychological models of seeking formal help and mental health care developed in the total population effectively explain help-seeking behavior in samples stratified by sex, age, and educational level. (JAC)

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Seeking Mental Health Care:
Multivariate Analysis of a National Survey

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ABSTRACT

SEEKING MENTAL HEALTH CARE:
MULTIVARIATE ANALYSIS OF A NATIONAL SURVEY

by
Irving Glenn Leon, Ph.D.

Data collected in a large national survey of help-seeking behavior and psychological well-being were coded into over fifty independent variables representing five conceptually distinct psychological categories (i.e., Distress, Intrapsychic measures, Help-Seeking variables, Resources and Values). Three psychological models of help-seeking behavior--the health belief model, socio-cultural perspective and ego psychological model--were evaluated using these five conceptual categories. Seeking any kind of formal help and mental health care in particular were analyzed using a multivariate regression analog, logit analysis.

The health belief model seemed to best account for the decision to seek formal help based on perceived impaired functioning. However, results from this study suggest that the stage of deciding to seek some kind of formal help prior to the choice of agent may be more an artifact of stage theories of help-seeking behavior than a step made by the help-seeker. Seeking mental health care rather than other kinds of formal help was best predicted by the social network factors of the socio-cultural perspective; this

suggests that situational factors, particularly those related to the help-seeking process, play a much more important role than enduring, internalized predispositions and reported distress. The importance of belonging to a mental health reference group which normalizes and reduces the stigma of seeking mental health care was highlighted. Multivariate psychological models of seeking formal help and mental health care developed in the total population effectively explain help-seeking behavior in samples stratified by sex, age and educational level.

Most studies investigating the decision to seek mental health care have focussed on socio-demographic differences in health utilization behavior. Many of the early studies were conducted before the current theories of health behavior became well-defined. Most of these studies were atheoretical "fishing expeditions" in which statistically significant but often conceptually unrelated socio-demographic and behavioral variables were cited without any examination of which intervening psychological mechanisms were operating (e.g., Boyce & Barnes, 1966; Davidson & Hutt, 1964; Davie, 1958; King, 1968). Findings from these studies and several others (i.e., Greenley & Mechanic, 1976; McMichael & Hetzel, 1974; Scheff, 1966; Veroff et al., 1981b) reach considerable consensus that people are more likely to seek psychotherapy if they are female, well-educated, Jewish, from an urban background and not religious. However, the frequency with which any sub-group seeks a mental health consultation may be based on many different psychological variables such as psychological-mindedness, attitudes to mental health services, readiness to seek professional help, how distress is experienced, and social network structure. More recent investigations have explored which intervening psychological mechanisms may account for different utilization rates among different social classes (Kulka et al., 1979) and the sexes (Horwitz, 1977a; Kessler et al., 1979; Kessler et al., 1981). In the same vein, other recent studies (see Greenley & Mechanic, 1976

and Veroff et al., 1981b) simultaneously examine and control for these different categories of variables in order to parcel out their independent and interactional influence on the decision to seek mental health care (i.e., how much of attitudinal, knowledge and reference group differences may be tied to socio-demographic factors such as sex or social class).

Understanding which psychological mechanisms account for socio-demographic differences in health utilization behavior seems to have overshadowed the more fundamental task of constructing a generalized psychological model of mental health help-seeking for the total population. Whether such a generalized model has more than heuristic value by predicting health utilization behavior within individual sub-groups may be assessed by applying the generalized model within samples stratified by basic socio-demographic categories such as sex, age and educational level. This paper reports an empirical evaluation of three psychological explanations of help-seeking behavior--the health belief model, socio-cultural perspective, and ego psychological approach. Despite the important role these three theoretical orientations have played in guiding the understanding of health actions and inaction, no study has systematically compared their differential utility in predicting the decision to seek any kind of formal help for emotional problems and mental health care in particular.[1] After these three

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[1]The author recognizes that these three theories are

theoretical orientations are briefly reviewed, several methodological considerations will be discussed before the hypotheses are stated.

Theoretical Orientations

The "health belief model" views health-oriented behavior as the product of a rational decision-making process in which the dangers of nonaction are weighed against the merits and costs of a potential treatment. "Health behavior is determined by the degree to which a person sees a health problem as threatening, having both serious consequences and a high probability of occurrence in his case; and by the extent to which the motivated individual believes that some one of several courses of actions open to him will be effective in reducing the threat " (Rosenstock, 1960:298). The principal components of the model, therefore, are one's health-related motivations, perceived susceptibility and perceived severity of illness, and potential benefits and obstacles to seeking treatment (Becker et al., 1977; Rosenstock & Kirscht, 1979).

The health belief model helps to explain medical care utilization in many studies (Becker et al., 1977), although it has rarely been applied to the decision to seek mental

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not necessarily mutually exclusive and may be integrated for a fuller understanding of health utilization behavior. However, since the purpose of this paper is to evaluate these three approaches and not to provide a theoretical integration, they will be regarded as distinct perspectives representing divergent theoretical and empirical studies.

health care. While many studies found a significantly higher reported level of distress and number of problems among those seeking a mental health consultation compared to a non-treatment control group (Davidson & Hutt, 1964; Davie, 1958; Fink et al., 1969; Greenley & Mechanic, 1976; King, 1968; Scheff, 1966), these differences were not very powerful in accounting for the decision to seek professional psychological help. None of these researchers (except for Fink and his colleagues) conclude that a mental health help-seeking group is clinically more disturbed than a non-treatment control group. Many people who report high levels of distress not only do not seek psychological help (Greenley & Mechanic, 1976; McMichael & Hetzel, 1974; Veroff et al., 1981b), but are significantly less inclined to seek such help than those reporting less severe distress (Calhoun & Selby, 1974; Calhoun et al., 1972). Perceived severity of one's condition, perhaps the most important inducement to seeking help in the health belief model, does not seem to be a very important factor motivating the decision to seek mental health care.

The socio-cultural perspective is basically a socialization model in which interpretations, meanings and actions regarding health and illness are considered the product of one's social environment and social structure. This second orientation considers differences in 1) interpretations of symptoms; 2) readiness to seek help; 3) sick-role attribution; and 4) social network structure

among different sub-groups of the population as crucial in explaining differences in health care utilization. This approach, emphasizing socio-demographic differences, is the prevailing orientation used to understand the decision to seek mental health care. For example, the higher rate of professional help-seeking among women has been associated more convincingly with their greater readiness to seek psychological help (Kessler et al., 1979) and their greater tendency to define problems in psychiatric terms warranting professional help (Horwitz, 1977a; Kessler et al., 1981) than a greater number of problems compared to men. Such an analysis of intervening psychological variables helps to clarify whether the health belief model or socio-cultural orientation better accounts for differential rates of health utilization behavior.

Social network structure may affect the decision to seek mental health care in several different ways. Social support may reduce the need for help by moderating life stressors (Cobb, 1976). However, a recent national survey of help-seeking found no major association between measures of psychological well-being and the size of one's social support network (Veroff et al., 1981b) or subjective mental health and using informal help (when socio-demographic controls are applied) (Veroff et al., 1981a). The cohesiveness and breadth of one's social network may exert a strong influence on whether mental health care is sought for an emotional problem (Horwitz, 1977b; 1978; Lieberman, 1965),

much like social network structure has been found to affect the utilization of medical services (Friedson, 1960; McKinlay, 1973; Suchmann, 1965a). These researchers have found that people with less cohesive family ties and a broader, more diversified friendship structure have greater psychological and practical access to referrals for medical and mental health care services. Finally, the values and belief system of one's reference group may be an important factor in the decision to seek mental health care. Kadushin (1966, 1969) has described how a certain social circle--"the friends and supporters of psychotherapy"--which is defined by cultural activities, psychiatric sophistication and having sought psychotherapy may facilitate the decision to seek psychological help and where one goes for help by influencing problem interpretation and providing a referral.

The pervasive devaluation and stigmatization of the mentally ill in virtually all evaluative categories and by all socio-demographic groups has been consistently reported in surveys for over twenty years (Nunnally, 1961; Olmsted & Durham, 1976; Rabkin, 1972). As one review of the literature summed up, "In a very real sense, mental patients have taken the place of lepers as targets of public disgust, dislike and rejection" (Rabkin, 1972:154). In light of the public's tendency to normalize and deny even severe emotional disturbance (Cumming & Cumming, 1957; Sampson et al., 1965; Yarrow, Schwartz et al., 1955), it is not surprising to find that attribution of emotional illness,

and the associated stigmatization, is frequently based on seeking professional help. "Even when the normal person is described as seeing a psychiatrist, he is rejected more than a simple schizophrenic who seeks no help" (Phillips, 1963:969). Yet, despite the potential importance of this factor, the impact of anticipated public stigmatization and self-devaluation from seeking mental health care on the decision to seek such help has been virtually unexamined. In addition to the factors already described, particular reference group affiliation may facilitate the decision to seek mental health care by reducing the stigma associated with seeking such help and by moderating the cultural psychiatric sick-role. One may be more likely to seek mental health care if one expects to receive less public stigmatization and believes a less severe experience of distress legitimates a need for treatment.

The third psychological model applied to explain health utilization is an ego psychological approach, emphasizing often unconscious motivations and defenses which may influence the decison to seek professional help. The more subjective and less concrete experience of psychological distress as opposed to physical symptoms probably makes psychological distress more susceptible to minimization and magnification by the lens of psychological defenses. While not empirically assessed in depth, it has been suggested that denial of distress is a potentially important factor accounting for a fixed, self-reliant attitude among some of

those who could never imagine seeking formal help for an emotional problem (Veroff et al., 1981b). At the other extreme, the experience of psychological distress may be associated with greater introspectiveness (Mechanic, 1979a). Despite the obvious relevance of one's psychological orientation to seeking mental health care, this factor has never been the focus of intensive investigation, typically summarized in a brief index which is vaguely defined (King, 1968; Snyder & Kahne, 1969) or of low reliability (Greenley & Mechanic, 1976). Does psychological orientation directly affect help-seeking behavior or is it a mediator of distress? Does it exert its influence as a generalized personality trait or only in the interpretation of the particular presenting problem for which help is sought? These are important, unresolved questions in the decision to seek mental health care.

Methodological Considerations

Most of the empirical studies investigating the decision to seek mental health care suffer from many methodological and analytic flaws (see Table 1). Typically, a very restricted context is used in which only one treatment alternative by a specific, homogeneous population is evaluated without considering informal help-seeking or multiple measures of distress. The generalizability of many studies is seriously limited by the narrowness of the population sampled (i.e., typically college undergraduates).

The homogeneity of this commonly used population in terms of age. education and social class, combined with their typically high levels of distress (Mechanic & Greenley, 1976; Snyder & Kahne, 1969) make this an obviously unrepresentative sub-sample of the total population.

Generalizing results from a single treatment source may lead to quite erroneous conclusions. While the most frequently cited sociological factor distinguishing those who sought psychotherapy from a non-help-seeking control group is the lack of religious involvement (Boyce & Barnes, 1966; Davie, 1958; Greenley & Mechanic, 1976; King, 1968; Scheff, 1966; Snyder & Kahne, 1969), this does not mean that those who are more religious rely less on all formal sources of help to deal with emotional problems. Those who seek some kind of formal help are significantly more likely to identify with a religious denomination (Greenley & Mechanic, 1976) or attend church regularly (Veroff et al., 1981b), with a sizable segment turning to their clergy when in need of help. It is necessary, therefore, to distinguish factors related to seeking any kind of formal help for an emotional problem from those relating to seeking a specific kind of help, such as mental health care (Mechanic, 1975). Based on their study of formal help-seeking among university students, Greenley and Mechanic (1976:253) concluded that "most social and cultural factors operate less in the decision to seek help than they do in the decision concerning where to seek help."

TABLE 1

Summary of Methodological and Analytic Features of Studies of Seeking Mental Health Care

Study	Methods						Data Analysis	
	Diverse sample[a]	>1 help choice	Informal help measured	>1 distress measure	Prospective design	Use of psych vars	Use theoretical models	Multivariate
Bart, 1968	-	+	-	-	-	-	+	-
Boyce & Barnes, 1966	-	-[b]	-	+	-	-	-	-
Brown, 1978	+	+	+	+	+	+	+	-
Davidson & Hutt, 1964	-	-	-	-	-	-	-	-
Davie, 1958	-	-	-	+	-	-	-	-
Fink et al., 1969	+	-	-	+	+	-	-	-
Greenley & Mechanic, 1976	-	+	-	-	+	+	+	+
Gurin et al., 1960	+	+	+	+	-	+	+	-
Kadushin, 1969	+	+	+	+	+	-	+	-
King, 1968	-	-	-	-	-	-	-	-
Linn, 1967	-	-	+	-	+	+	+	-
McMichael & Hetzel, 1974	-	+	-	-	+	+	+	+
Scheff, 1966	-	-	-	-	+	-	+	+
Snyder & Kahne, 1969	-	-	+	+	-	+	+	-
Veroff et al., 1981b	+	+	+	+	-	+	+	+

Note: (+) indicates study includes this feature.
(-) indicates study does not include this feature.

[a]This means the sample included both sexes and people of different ages and educational levels.

[b]This study did not distinguish mental health from non-mental health agents, making it impossible to evaluate the decision to seek mental health care.

The decision to seek some kind of formal help is distinguished from the choice of a particular help source[2] in most stage theories of health utilization behavior (e.g., Gurin et al., 1960; Kadushin, 1969; Mechanic, 1978; Suchmann, 1965b; Veroff et al., 1981b). However, it is possible that the stage of seeking any formal help is more an artifact of stage models than a meaningful experiential part of the help-seeking process. Perhaps people do not decide to seek help in the abstract, but, rather, embedded in their decision to seek some kind of formal help is the choice of a particular help source. If the choice of agent is an integral part of the decision to seek formal help, it is less likely that one agent will be substituted for another than if the choice is a discrete step after one has decided to seek some form of professional help. It seems unlikely for someone who structures his/her difficulty in a psychological manner and has few religious beliefs to consult a clergyman or a physician if a psychotherapist was unavailable for some reason.

The common failure to simultaneously assess informal help sources (i.e., family and friends) obscures the evaluative, preventative and lay treatment functions potentially served by one's social network. In times of crisis, informal help agents were used more often than professional ser-

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[2]As discussed here, the choice of agent refers to which broad category of formal help is consulted (e.g., mental health, general medical or clerical) as opposed to the choice of a particular practitioner or agency.

vices (Veroff et al., 1981b) and rarely is formal help used exclusively without earlier informal aid or consultation (Brown, 1978; Kadushin, 1969). The importance of multidimensional scaling of distress is highlighted by the low intercorrelation of different measures of distress (Veroff et al., 1981a), making the validity of using a single, undifferentiated problem checklist quite questionable.

Virtually all studies of seeking mental health care share the serious methodological flaw of using a retrospective design, collecting measures of distress, attitudes, and behavior concerning the decision to seek mental health care after the fact. This may lead to inaccurate causal interpretations of results in at least three distinct ways. Deciding to seek professional help may subsequently change attitudes in order to avoid post-decisional conflict and reduce cognitive dissonance (Janis & Mann, 1968). The act (and outcome) of obtaining professional help may modify certain key variables such as level of distress, psychological orientation, and attitudes towards the help. Finally, retrospective design may lead to erroneous interpretation due to the instability of certain variables from one time interval to another. By understanding the ways in which retrospective design may influence results, one may at least be in a better position to interpret those findings.

Except for retrospective design, none of the remaining seven methodological and analytic flaws commonly occurring in other studies of seeking mental health care summarized in

Table 1 will apply to this investigation. Recommendations for a large-scale national survey utilizing a wide range of variables in a multivariate design (Mechanic, 1979b) as well as the "development and testing of models that incorporate subjective definitions of symptoms, [and] alternative modes of treatment" (Kirscht, 1981:9) are satisfied by this study.

Hypotheses

Large-scale empirical studies have generally failed to find important psychological determinants of health care utilization, while smaller scale research has found such factors useful (Mechanic, 1979b). This study attempts to illustrate the usefulness of applying intervening psychological variables and models of health utilization in explaining help-seeking behavior in a large-scale study. Without an empirical demonstration of the utility of these psychological models and variables, purely practical aspects of accessibility (i.e., economic, geographic and organizational) or an atheoretical empiricism may guide more future research. Whatever its empirical value, a decision-making model which ignores cognitions, motivations, emotions, and behavior leaves the decider out of the decision process and promotes little understanding of the help-seeking process.

> Hypothesis 1 The decision to seek formal help or not will be best accounted for by the health belief model. The most crucial factor directly associated with seeking formal help will be the level of impaired functioning.

Hypothesis 2 The socio-cultural and ego psychological perspectives will better explain the choice of a mental health agent than the health belief model. Impaired functioning and one's degree of distress will be much less important in accounting for the decision to seek mental health care than one's psychological orientation and help-seeking factors. In particular, one's psychological orientation in general as well as to the presenting problem, how psychologically distress is experienced, knowing someone who sought mental health care, and having access to an informal referral source will be the most important factors facilitating seeking mental health care.

Hypothesis 3 These psychological variables will play a much more powerful role in determining the choice of help agent than in determining whether formal help is sought or not. The model predicting the choice of a mental health agent vs. other formal agents will explain a much greater proportion of the variance than the model predicting seeking any formal help or not.

METHODS

Sample

The data were obtained from a national survey conducted by the Survey Research Center at The University of Michigan in 1976 (see Veroff et al., 1981a; 1981b for a detailed description of methods), replicating an earlier study (i.e., Gurin et al., 1960). A national sample of 2264 adult participants representative of the American population on major socio-demographic characteristics were interviewed in depth in their homes about their sense of well-being and help-seeking behavior. The population was sampled using a multi-stage probability area design (see Kish and Hess, 1965 for more detail), in which a number of primary sampling points in different regions within the coterminus United States were distinguished. Sampling within these units was propor-

tional to their representation in the recent census. The response rate of completed interviews was 71%. This completed sample did not differ significantly from the sociodemographic composition of the general population based on the 1976 census, using such criteria as sex, age, education, race, marital status, region and family income.

Measures

Dependent measures

The two dependent measures are dichotomous, categorized by whether any formal help had ever been sought by the respondent (i.e., seeking formal help[3]) and, if so, whether a mental health agent had been selected (i.e., seeking mental health care). For the first measure, seeking formal help, 53% or 1192 reported having sought some kind of formal help for an emotional problem or crisis in the past, and the remaining 47% or 1072 reported never having done so. Of those who sought some kind of formal help, 31% or 369 reported seeking mental health care, while the remaining 69% or 823 described going to another source of professional help.

The very high rate of formal consultation reported--over 50% of this sample--probably reflects the procedure of inquiring about both a broad range of problems and a wide

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[3]To simplify presentation of methods and results, specific dependent and independent variables described in the text will be underlined.

spectrum of potential help agents. While most formal help-seeking responses were elicited to two inquiries (one asking about personal problems and the other asking about crises), 10% of those who sought formal help did so only in response to other difficulties (i.e., worries, sadness, marital problems in current or former marriage, or when one felt one was going to have a nervous breakdown). Mental health professionals, physicians, and clergymen were the agents most commonly consulted, although nurses, teachers, lawyers and other formal help agents were included. A wide range of resources was, similarly, categorized as mental health agents, including individual practitioners (e.g., psychiatrists, psychologists and social workers), clinics (e.g., child guidance clinics and substance abuse programs), and hospitals (specifically designated as mental). Assessing multiple use of formal agents was not attempted. A formal help-seeking response is defined as <u>any</u> consultation of a formal agent among any of the multiple opportunities to give such a response. Similarly, assessing multiple use of mental health resources was not attempted.

Independent measures

Five conceptual categories were distinguished to evaluate the empirical utility of the three psychological perspectives described. The Distress measures and Resources (except for <u>social integration</u> and <u>marital status</u>) are most closely associated with the rational decision-making process

of the health belief model. The socio-cultural approach is represented by the Help-Seeking variables and interpersonal Resources just mentioned. The ego psychological perspective is based on the Intrapsychic measures and Values. Each of these five conceptual categories includes at least eight different variables (see Table 2). In addition to categorizing the independent variables within these five conceptual groups, the locus of causality of variables was roughly distinguished in order to assess the comparable contribution of enduring, internalized factors vs. transient, situational influences. For example, most Help-Seeking measures were designated as situational factors. All Intrapsychic variables were considered internalized factors except for psychological orientation to presenting problem, a situational-internalized influence. Another variable categorization was helpful: Two variables (i.e., psychological orientation to presenting problem and referral source) specifically referred to a help-seeking episode; all the remaining variables did not.

The consistent use of the same basic interview schedule, allowance for individual, personal responses and the development of categorical or more refined coding devices enabled 1) the assessment of people's subjective understandings of problems and well-being rather than resorting to only standardized "objective" checklists and forced-response questions and 2) the possibility of more rigorously comparing participant responses using multi-

TABLE 2

Categorization of Independent Variables

Conceptual category	# of vars	Independent variables
Distress	15	Past unhappiness, Present unhappiness, Worries, Physical ill health, Psychological anxiety, Alcohol usage, Impaired functioning, Leisure dissatisfaction, Low self-esteem, Anomie, Role inadequacy, Marital dissatisfaction, Work dissatisfaction, Degree of distress,[a] Severity of nervous breakdown
Intrapsychic	15	Psychological orientation to worries, Psych. or. to happiness, Psych. or. to current unhappiness, Psych. or. to past unhappiness, Psych. or. to aspirations, Psych. or. to crisis, Psych. or. to presenting problem, Denial of symptoms, Denial of problems, Denial of role inadequacy, Denial of marital problems, Denial of crises, Externalization, Vagueness, Vague description of presenting problem
Help-Seeking	8	Informal help-seeking, Informal help-seeking during a crisis, Informal advising of further help, Mental health reference group, Church attendance, Readiness to seek formal help, Readiness to seek mental health care, Referral source
Resources	8	Efficacy, Optimism, Social integration, Marital status, Coping alternatives when worried, Coping alternatives when sad, Coping alternatives if sad, Coping alternatives if had marital problem
Values	4	Power, Affiliative need, Affiliative value, Central value

[a]This variable is a composite of all prior Distress measures, omitting the less reliable "past unhappiness," and is included in the model only when all other Distress measures are not.

variate analysis. Three kinds of independent variables were constructed, depending upon the scaling approach which was most feasible: 1) quantitative independent variables based on interval scaling;* 2) dichotomous independent variables generally based on a yes/no response to a single question such as membership in a mental health reference group; 3) categorical independent variables represented in individual dummy variables. For more details on scale construction, composition of variables, and descriptive statistics of measures, the reader is referred to the author's original work on which this paper is based (Leon, 1983).

Data Analysis

Logit analysis was used to analyze the data since it has been found to be the most accurate method of assessing predictors of a dichotomous, dependent variable (Fienberg, 1977; Hanushek & Jackson, 1977; Press & Wilson, 1978; Smith, 1982). Although logit analysis is associated with chi-square binary distributions (Cox, 1970), its output provides an analogue to least squares regression. This enables a

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*Using Cronbach's alpha as a measure of internal consistency, .4 was considered a minimum acceptable standard for scales. Although Nunnally (1967) suggests a somewhat higher minimum level of internal consistency (i.e., .5-.6 for exploratory research), this lower level is considered tolerable in light of the multiple variables used to index a conceptual category, making it less necessary to use a higher minimum standard for every variable. Of the twenty-six scales using more than one item, only three had an internal consistency below .5 and the majority were over .6.

measure of explained variance for the multivariate model,[5] as well as t-test estimates and measures of explained variance for the unique contribution of each independent variable in predicting the dependent variable.

In order to derive the "best model" (i.e., the set of variables accounting for the most variance in the dependent variable), the entire set of independent variables was reduced via least squares regression to those significantly associated with the dependent variable in bivariate relationships. Due to the expense of logit analysis and the reasonably accurate estimates provided by least squares regression (see Kobashigawa & Berki, 1977; Wolinsky, 1978), this seemed to be the most practical approach to the preliminary data analysis. In the multivariate model, the attrition of cases due to missing data was handled by constructing non-missing versions of those variables with a sizable proportion of missing data, substituting the mean (in interval scales) and the mode (in categorical scaling) for the missing cases. The additional inclusion of a dummy variable indexing which cases were originally missing provides a correction for this non-missing version with a measure of the relationship between the missing data and the dependent variable, independent of the associated non-

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[5]Although logit analysis does not yield a measure of explained variance in the same manner as linear regression, it permits an analogue of "r^2," namely the estimated probability that each case has the classification observed or the reduction in error in outcome prediction afforded by the independent variable(s) (Fleiss, 1981; Smith, 1982)

missing, substantive variable itself (Cohen, 1968)

Multicollinearity, the intercorrelation of independent variables, is sometimes a major obstacle to assessing the association between a predictor and the dependent variable, independent of the other predictors (Hanushek & Jackson, 1977). Multicollinearity was reduced by paring down the multivariate model to only those variables which, within the model, provided an additional, unique contribution to the prediction of the dependent variable. The independent variables in the final model were invariably the most powerful predictors among the earlier, bivariate relationships. Examination of the intercorrelation matrices of the independent variables for both models of seeking formal help and seeking mental health care suggests that multicollinearity did not become a major problem. (The interested reader is referred to Appendix C of the original work (Leon, 1983) where the matrices are presented.) The unique contributions of the most powerful independent variables and the five conceptual categories in predicting help-seeking behavior was computed by subtracting the explained variance afforded by the model without that particular variable or category, from the complete multivariate model. This approach enabled an assessment of the most powerful variables and categories in predicting help-seeking behavior independent of the remaining variables. A constant sample size was used as a base in determining the unique contribution of different partitions of the model, so that variations in the sample size was not

introduced as an uncontrolled factor affecting the results.

In order to evaluate how well the model for the total population functions within basic socio-demographic subgroups, the multivariate logit analyses of seeking formal help and seeking mental health care were run for each sex, three age groups (i.e., the young--21-34, the middle-aged--35 to 54, and the elderly--over 55), and for three educational levels (i.e., grade school graduate, high school graduate and at least some college).

RESULTS

Due to large sample size, very statistically significant findings (i.e., $p<.002$) may account for a trivial proportion of the variance (i.e., less than .01). Since my primary aim is explaining rather than predicting the factors involved in help-seeking behaviors, seemingly minor findings based on a low proportion of explained variance may still assume considerable theoretical importance. With both these considerations in mind, only those predictors which uniquely account for at least 2% of the variance in the multivariate model will be highlighted in the following tables, while the less powerful but statistically significant variables in the model will be listed. The relative importance of different independent variables and conceptual categories will be evaluated by a non-statistical comparison of the measures of explained variance. The bivariate relationships will not be reported here since the principal goal is to construct the

best models of help-seeking behaviors, controlling for intercorrelations among the predictors, in order to evaluate the three psychological perspectives. (The interested reader is referred to Appendix D in the original work (Leon, 1983) for a presentation of the bivariate relationships based on both logit and linear regression computations).

Seeking Formal Help

In the model best accounting for the decision to seek formal help, impaired functioning is not only the most important variable, but the only predictor explaining a non-trivial proportion (i.e., over 2%) of the variance (see Table 3). The extent to which one feels debilitated is a more powerful factor motivating formal help-seeking than one's psychological orientation and use of defenses, and of equal importance with the entire group of four significant Help-Seeking factors (see Table 4). While clearly the most important variable in this model, impaired functioning still only accounts for a small share--about 3%--of the variance in seeking formal help. The negligible amount of explained variance (i.e., less than .5%) of the significant association between the degree of distress and seeking formal help highlights how it is less one's overall level of distress than how distress is perceived to interfere with one's functioning which motivates help-seeking behavior.

The primary role of impaired functioning supports, therefore, the importance of the health belief model in the

TABLE 3

The Model Predicting Seeking Formal Help
(By Variable)

Independent variable	t-test	Vars explaining at least 2% of variance	
		Exp var[a]	chi-square
Impaired functioning	9.5831****	.03	99.40****
Denial of crises	-7.0715****		
Psychological orientation to crisis	-6.0897****		
Informal help-seeking during a crisis	5.5223****		
Mental health reference group	5.0454****		
Informal advising of further help	4.6982****		
Church attendance[b]	4.3258****		
Degree of distress[b]	4.1754***		
Present unhappiness	-3.6401***		
Denial of problems	-3.4217***		

***p<.01 ****p<.002 N=2182 9 predictors

[a]As discussed more fully in the methods section, this proportion reflects the unique contribution of an independent variable, net of its correlation with other significant variables. This is found by computing the difference between the two test statistics (i.e., the model with and without that variable), which has an asymptotic chi-square distribution. The degrees of freedom is just the difference between the number of variables of the two models (i.e., 1 unless otherwise noted).

[b]This variable was not included in the final model and was tested by being added to, rather than omitted from, the model.

TABLE 4

The Model Predicting Seeking Formal Help
(By Category)

Category	Explained variance	chi-square	df
Help-Seeking	.03	110.37****	4
Distress	.03	98.68****	2
Intrapsychic	.02	94.69****	3
Situational-internalized	.03	118.59****	2
Situational	.03	110.37****	4
Internalized	.02	88.78****	3
Multivariate model	.11	437.81****	9

****p<.002

decision to seek formal help. The perceived severity and seriousness of the condition motivates formal help-seeking. At the same time, the equal or near equal contribution of explained variance by Intrapsychic and Help-Seeking factors indicates that the ego psychological and socio-cultural perspectives are also needed to account for the decision to seek formal help. Just as a more serious and debilitating expression of distress impels one to seek some kind of formal help, an unwillingness to acknowledge any problems or unhappy events seems to serve as an obstacle to seeking such help. Social network factors such as having obtained informal help during a crisis, receiving encouragement to obtain more help and knowing someone who sought mental health care

also facilitate one's seeking formal help. Hypothesis 1 is partially confirmed.

TABLE 5

Summary Comparisons of Seeking Formal Help Within Socio-Demographic Sub-groups

Sub-group	Explained variance[a]	% of 3 most sig vars in tot pop sig in sub-group ($p<.01$)	% of 6 most sig vars in tot pop sig in sub-group ($p<.1$)
Men	.14	100%	100%
Women	.12	100%	100%
21-34	.14	100%	100%
35-54	.12	100%	83%
Over 55	.15	100%	100%
Grade	.19	100%	100%
High school	.11	100%	100%
Some college	.13	100%	83%
Total pop	.12	100%	100%

[a]These measures are based on running an expanded version of the multivariate model.

In order to assess how well this model developed from the total population operates within individual socio-demographic sub-groups, the same model was applied to both sexes and different ages and educational levels (see Table 5). The multivariate formal help-seeking model accounts for as much if not more explained variance in virtually every socio-demographic sub-group as it did in the total popula-

tion. When the most important variables are considered, the model functions in essentially the same manner. The three most powerful variables in the total population are significant to at least the .01 level within each socio-demographic sub-group. A more lenient standard of .1 was applied to assess whether this congruence between how the model functions in the total population and specific sub-groups occurs with the six most important variables which account for over 80% of the explained variance of the multivariate model. In virtually every instance, 46 out of 48 times, it does. In no instance is there a significant finding in the opposite direction between different socio-demographic sub-groups and the total population.

Seeking Mental Health Care

An overview of the model of the decision to seek mental health care vs. other kinds of formal help provides a striking contrast to the results just reported regarding seeking formal help in general (see Tables 6 and 7). Not only does this model explain a considerable proportion of the variance in seeking mental health care--about a third--but the importance of the different conceptual categories is clearly ordered. Help-Seeking variables represent by far the most important dimension, uniquely contributing about twice as much to the measure of explained variance as the second most important category, Intrapsychic measures. The role of Distress indicators is negligible. Help-Seeking variables and

Intrapsychic measures uniquely explain, respectively, roughly 20 and 10 times the variance accounted for by Distress measures.

TABLE 6

The Model Predicting Seeking Mental Health Care
(By Variable)

Independent variable	t-test	Vars explaining at least 2% of variance	
		Exp var	chi-square
Psychological orientation to presenting problem	9.4088****	.08	116.35****[a]
Mental health reference group	6.9369****	.03	49.94****
Self referral	-6.0267****	.03	37.79****[a]
Formal referral[b]	4.1163****		
Informal referral[b]	3.9659****		
Church attendance	3.8679****		
Readiness to seek mental health care	3.7128****		
Physical ill health	-3.4036***		
Externalization	-2.9120**		
Psychological orientation to past unhappiness	2.5056**		
Seeking formal help when sad	2.4702**		
Impaired functioning	2.2373**		
Degree of distress[b]	-.0641		

**p<.05 ***p<.01 ****p<.002 N=1106 11 predictors

[a] df=2

[b] These variables were not included in the final model and were tested by being added to, rather than omitted from, this model.

The most important single variable in the decision to

TABLE 7

The Model Predicting Seeking Mental Health Care
(By Category)

Category	Explained variance	chi-square	df
Help-Seeking	.17	276.58****	8
Intrapsychic	.09	144.87****	6
Distress	.01	12.66***	2
Referral source	.09	138.96****	3
General psychological orientation and defenses	.01	16.75***	4
Situational	.16	255.17****	6
Situational-internalized	.09	141.76****	3
Internalized	.03	41.81****	7
Help-episode	.17	269.13****	5
Non-help-episode	.10	146.96****	11
Multivariate model	.33	559.18****	16

***p<.01 ****p<.002

seek a mental health consultation is psychological orientation to presenting problem, explaining 8% of the variance. Seeking mental health care is associated with a more emotional and personal, as opposed to concrete, physical and external, interpretation of the presenting problem.

A more psychological interpretation of problems given professional attention does not mean, however, that those who seek mental health care are more psychologically oriented in general. More general indicators of psychological orientation (i.e., psychological orientation to past un-

happiness) and use of psychological defenses (i.e., externalization) show a significant, but trivial, association with the decision to seek a mental health consultation. Furthermore, psychological orientation to past unhappiness appears to be more conceptually linked to the interpretation of the presenting problem than to one's general psychological orientation. This is empirically supported by at least a moderate correlation of .22 between these two measures of psychological orientation.

Help-Seeking factors made up of social network variables and one's readiness to seek mental health care clearly comprise the most important conceptual category influencing the choice of professional psychological help. In particular, the referral source is a critical factor; it uniquely explains 9% of the variance. The relatively low proportions of explained variance accounted for by self referral and formal referral individually are due to multicollinearity, as these two dummy variables are highly correlated (i.e., -.63). Whenever a referral is provided--whether by a friend, family member, or a professional--one is more likely to seek mental health care than when one is self-referred.

Reference group associations also emerge as an important factor in seeking mental health care, particularly knowing a relative or close friend who sought professional psychological help. While belonging to a mental health reference group is positively associated with obtaining

psychological help oneself, a greater religious affiliation (i.e., greater frequency of church attendance) increases the likelihood of seeking non-psychological forms of professional help (such as the clergy).

The socio-cultural perspective seems to best explain the decision to seek mental health care as opposed to other kinds of formal help. Factors associated with the particular episode for which professional help was sought--interpreting the presenting problem in more psychological terms and having a referral source other than oneself--clearly provide the most explanatory power in accounting for the choice of a mental health agent. More general Help-Seeking variables related to one's social network (i.e., belonging to a mental health reference group and church attendance) and one's readiness to seek mental health care are also of some importance. The experience of distress--its overall level, impairment of functioning, and how psychologically it is manifested--plays a negligible role in the decision to seek mental health care vs. other kinds of formal help.

Seeking a mental health consultation does not seem rooted in internalized factors, but is more a product of situational influences associated with the help-seeking process. While the Intrapsychic measures contribute a substantial proportion of explained variance to the model, this is not based on a more pervasive psychological orientation to the world, but on how psychologically one interpreted the

specific presenting problem for which help was sought. The ego psychological model, therefore, does not provide much help in understanding the decision to seek mental health care in this study. Similarly, health belief theory, with its emphasis on the rational assessment of the severity of one's condition weighed against one's resources and coping ability in deciding to seek help, does not meaningfully contribute to the empirical model accounting for the decision to seek mental health care. Hypothesis 2 is confirmed.

TABLE 8

Summary Comparisons of Seeking Mental Health Care Within Socio-Demographic Sub-groups

Sub-group	Explained variance[a]	% of 3 most sig vars in tot pop sig in sub-group ($p<.01$)	% of 6 most sig vars in tot pop sig in sub-group ($p<.1$)
Men	.34	67%	100%
Women	.40	100%	100%
21-34	.34	100%	100%
35-54	.40	100%	83%
Over 55	.44	67%	100%
Grade	.34	67%	67%
High school	.47	100%	67%
Some college	.35	33%	100%
Total pop	.35	100%	100%

[a]These measures are based on running an expanded version of the multivariate model.

The multivariate model developed in the total population explains about the same or more variance when it is applied within socio-demographic sub-groups (see Table 8). With only one exception,[4] all significant findings in the total population and within individual socio-demographic sub-groups are in the same direction. The six most important variables accounting for about 90% of the variance explained by the multivariate model tend to function in the same fashion among both sexes and different age groups. The most important exceptions are the much less powerful association of self referral with non-mental health agents for men and the elderly. Compared with the total population, those with no more than a grade school education and those with some college education display greater differences in how the most important variables function. Among those who completed no more than a grade school education, psychological orientation to presenting problem, the most important variable in the total population, is only marginally associated with seeking mental health care. Two other relatively important variables associated with seeking mental health care in the total population--church attendance and a

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[4]An age difference in one instance is the only exception. There is a trend ($p<.1$) for physical ill health to be positively associated with seeking mental health care for the young, while it is negatively associated with seeking such help in the total population ($p<.05$), and especially among the elderly ($p<.01$). Unexpected and medically inexplicable physical complaints among the young (e.g., conversion symptoms) may be an inducement to seek mental health care. Physical complaints among the old are probably viewed as a natural by-product of aging and are more likely to lead to a medical consultation.

formal referral--are not significantly related with those with a grade school education. Among the college-educated, membership in a mental health reference group and using a referral source other than oneself--crucial variables in seeking a mental health consultation among the less educated--are much less significant. In applying the multivariate model developed in the total population to different socio-demographic sub-groups, noteworthy differences emerge with those at the extremes of education--those with no more than a grade school education or at least some college.

Deciding to Seek Formal Help vs. Choice of Agent

By comparing the proportions of explained variance accounted for by the models of seeking formal help and seeking mental health care, it becomes clear that these psychological variables are much more powerful in distinguishing among help-seekers, based on which agent is chosen, than in distinguishing help-seekers from non-help-seekers. The model explaining the decision to seek mental health care vs. other agents accounts for three times as much of the variance as the model explaining the decision to seek any kind of formal help.[7] The lack of general psychological factors applying

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[7]The magnitude of this difference is partially due to the considerable contribution of variables related to the specific help-episode, such as referral source and psychological orientation to presenting problem. These variables are not available in the analysis of the decision to seek formal help. When these variables are omitted from the analysis of choice of agent among all formal help-seekers, the amount of explained variance in the multivariate model accounting for the choice of agent was reduced

to all help-seeking behavior becomes clear when the multivariate model predicting seeking formal help is applied to those who sought mental health care (vs. no formal help) and to those who sought non-mental health care (vs. no formal help).* Almost half of the variables supposedly accounting for the decision to seek any formal help are significant in the help-seeking model for the total population only due to their great weight in explaining the choice of a mental health or non-mental health agent, and not general help-seeking at all. Even when predictors are significant for both mental health and non-mental health agents and can be viewed as representing generalized help-seeking factors, they often function much more importantly with one kind of agent or another. In fact, not one of the five most important variables in the model of seeking formal help in the total population seems to function significantly and with roughly the same magnitude for mental health and non-mental health agents. Hypothesis 3 is confirmed.

DISCUSSION

Methodological Issues Re-Visited

Three methodological issues which need to be addressed

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to .18, still over 50% greater than the 11% accounted for by the multivariate model of seeking formal help.

*These results will only be summarized in this paper. The reader is referred to the original work on which this paper is based (Leon, 1983) for a more detailed presentation of these findings.

in interpreting the results are retrospective design, self-report of measures, and construct validity. As already suggested, probably the most serious problems are created by retrospective design. Not only is distortion introduced by retrospective recall, but in this study many of the questions were phrased in the present. Naturally, a predictor assessing only current experience could not be expected to be as reliable as an index focussing on past functioning, prior to help-seeking. This aspect of retrospective design may, in part, explain the minor role played by several conceptual categories of variables. Resources and Values, virtually all of which were indexed in the present, showed no association with either seeking formal help or seeking mental health care. Conversely, the most powerful predictors in this paper, those specifically referring to the help-episode, benefitted by being temporally closest to the help-episode and perhaps were the most reliable variables.

If we apply the more rigorous criteria proposed by Robins (1969) to distinguish correlation and consequences from causal relationships, we are unable to unequivocally state that <u>any</u> of the significant findings are causal factors in the decision to seek formal help because none are assessed prior to the help-seeking episode. Difficult as it may be to arrange in clinical settings, more prospective studies of the decision to seek mental health care are desperately needed. There are too many sources of error inherent in reconstructing the decision process based on a

retrospective design (i.e., distortions in recall, instability of measures, and effects of deciding to seek and/or receiving help).

The validity of measures may be seriously lowered by data collection based solely on self-report without any independent records of help-seeking behavior, level of impaired functioning, etc. Self-report of physician contacts in health surveys is often seriously underreported (Kirscht, 1971). Social desirability may exert a systematic source of bias, especially affecting the self-report of distress and help-seeking behavior, depending upon one's willingness to reveal one's vulnerability and difficulties to an interviewer.

The seriousness of this problem may not be as great as first appears. Formal help-seeking behavior is assessed in this study by asking about seven different problem areas at different points in the interview and often in connection with everyday problems. The breadth of the inquiry about formal help-seeking and the fact that over half the total sample described seeking some kind of formal help for an emotional problem or crisis suggests that this study did not severely underestimate help-seeking behavior. The measurement of distress in general and impaired functioning in particular may be biased by the influence of social desirability and psychological defenses affecting one's self-report. However, since the Distress variables are not being used as objective measures of psychopathology, but as

indicators of the perceived severity of one's problems in the context of subjective health evaluation in the health belief model, the possible discrepancy between perceived and "objective" levels of functioning is not a problem for this study.

The multiple means of assessing both distress and help-seeking behavior--factors most likely sensitive to distortions due to self-report--as well as how reported measures of distress are interpreted in this study probably minimizes the potential problems created by self-report. This methodological problem pervades this area of research. Of all the studies of seeking mental health care reviewed, only one (see Fink et al., 1969) used independent observers to assess levels of distress and impaired functioning. Although self-report of measures will continue to be a methodological issue with which future research must grapple, it need not compromise validity as much as it seems to have done in the past if realistic adjustments in design and interpretation are made.

In evaluating construct validity, two separate aspects must be considered. First, how well do each of the independent variables used operationalize the underlying construct each one purports to measure? Second, how well do the five conceptual categories of variables adequately represent each of the three psychological models of help-seeking they are designed to assess? Since many of the independent variables were based on a single or a few items,

it was not expected that any measure would by itself adequately define or evaluate a complex construct.

The most serious problem in construct validity emerged in assessing psychological orientation. Measures of psychological orientation were based on single items, since no scales of psychological orientation combining several items could be created satisfying even minimum standards of internal consistency (i.e., over .4). There is no empirical support for a generalized construct of psychological orientation based on this study. It is no surprise that single items representing as complicated and probably multifaceted a construct as psychological orientation will have a limited reliability and validity (Nunnally, 1967; O'Grady, 1982), minimizing any association with help-seeking behavior. There was a positive association, in at least bivariate analyses, of most measures of psychological orientation with seeking mental health care. This suggests that perhaps certain aspects of psychological orientation may be more powerfully associated with help-seeking behaviors than these results indicate.

A more fundamental question for future research is determining whether there is an empirical basis for considering psychological orientation a single construct or even a composite of several factors. Perhaps psychological orientation is so situationally specific that it does not define a more pervasive approach to one's world. Since psychological-mindedness (or some variant such as introspec-

tion) has been frequently used in both psychotherapy decision-making studies (see Greenley & Mechanic, 1976; King, 1968; Snyder & Kahne, 1969) and outcome research (see Baekeland & Lundwall, 1975), more basic research is necessary to operationally define exactly what this construct means.

How well do these five conceptual categories assess the three psychological theories of help-seeking behavior? Each of the three psychological perspectives is represented by at least ten variables, highlighting crucial aspects of each theory. At the same time, important indices of each perspective are omitted or incompletely represented, thereby preventing a more comprehensive evaluation. For example, health motivation and expectation of treatment success, related to the health belief model, sick-role dimensions and the stigma associated with seeing a psychotherapist, relevant to the socio-cultural approach, and more sophisticated measures of psychological mindedness and other defensive operations such as rationalization and minimization, associated with an ego psychological perspective, are all absent. However, due to the omission of more aspects of the health belief model and the potential inadequacy of my measures of psychological orientation, construct validity is weaker in evaluating these two orientations than the socio-cultural perspective.

If all three methodological shortcomings are considered--retrospective design, self-report of measures,

and problems with construct validity--the socio-cultural perspective appears to be compromised least by this study's methodology. Since many of the results agree with these methodological constraints, further research which more adequately evaluates the health belief and ego psychological models is needed.

Seeking Formal Help

One of the most important findings of this study is the lack of uniformity found among those who have sought any formal help. The psychological differences among those who sought formal help exceed the differences between formal help-seekers and those who did not seek such help. These results replicate in a broader, nationally representative sample what Greenley and Mechanic (1976) found in their analysis of formal help-seeking behavior within a more homogeneous college population. They emphasized that socio-cultural, attitudinal, and distress differences operated more at the level of choice of agent than the decision to seek any formal help. The small proportion of explained variance afforded by my model accounting for formal help-seeking seems due to the heterogeneous nature of this group, composed of several diverse sub-groups of formal help-seekers. This reduces the measure of explained variance for the entire group (O'Grady, 1982). A study which limited its line of inquiry about help-seeking behavior to a more narrowly defined problem (e.g., only personal difficulties)

would probably yield a more homogeneous group of formal help-seekers which would not represent the diversity of all those who seek any kind of formal help for emotional problems.

Patterns and paths of seeking formal help are different enough that any model attempting to account for all help-seeking behavior is bound to be weak and misleading. This does not mean that assessing similarities in formal help-seeking behavior should be abandoned, since it may be important to distinguish those who seek some kind of formal help from those who do not. However, results from this study suggest that the stage of deciding to seek some kind of formal help prior to the choice of agent may be more an artifact of stage theories of help-seeking behavior than a step made by the help-seeker. It is necessary to sample help-seeking from numerous kinds of agents in order to avoid making ill-founded generalizations about help-seeking based on a single agent and to explore the considerable differences in formal help-seeking behaviors.

Seeking Mental Health Care

Perhaps the most notable result of the multivariate analysis of the decision to seek mental health care vs. other kinds of formal help is the great importance of the two help-seeking process variables--psychological orientation to presenting problem and referral source. The overriding importance in this study of factors specific to the

help-episode, as distinguished from more general measures, was also found in a recent multivariate study of seeking medical care (Berkanovic et al., 1981). That study highlighted the importance of symptom-specific social network factors and health beliefs related to a particular episode of seeking medical help, rather than social network factors and health beliefs in general. As noted by Berkanovic and his co-workers, however, the retrospective design of their study prevents a simple causal analysis between these independent variables and dependent help-seeking behavior: Someone who has already gone to a physician may later, in rationalizing his/her help-seeking action, come to believe the presenting problem was serious enough to warrant medical attention.

Similarly, the powerful association of one's psychological orientation to the presenting problem with the choice of a mental health agent may be a result, rather than a cause, of seeking mental health care as opposed to other kinds of formal help. The greater psychological orientation to the presenting problem held by someone who has sought a mental health consultation may represent his/her adopting the more psychological perspective probably offered by the psychotherapist. Otherwise, the investigator must explain why this particular problem is interpreted in more psychological terms and not other problems and issues in the mental health help-seeker's life. An alternative interpretation would be that this greater psychological orienta-

tion to the presenting problem represents not a causal factor motivating mental health care utilization, but a justification for that decision once it has been made. Even before consulting a mental health professional, an individual may be more likely to structure his/her problems in mental health terms, probably with input from informal consultation, as a "ticket" to getting professional psychological help. Structuring the presenting problem in more psychological terms may be, therefore, less a causal motivator to obtaining psychological help than the help-seeker complying with the demand to structure the problem in the appropriate way to receive such help.

If psychological orientation to presenting problem is omitted from the model, Help-Seeking variables almost exclusively account for the decision to seek mental health care. Deciding to obtain a mental health consultation as opposed to other kinds of formal help seems primarily based on one's social environment supporting that decision by destigmatizing the pervasively negative cultural attitude towards seeking mental health care. This view presupposes the importance of dismantling the formidable societal barriers of social stigmatization erected against seeking mental health care. The following discussion highlights this interpretation of the results.

Using a referral source other than oneself is very powerfully associated with seeing a mental health professional as opposed to another source of formal help. This

may be due to a lack of information resulting from the greater social distance separating mental health practitioners (as opposed to other professionals) from prospective patients (Kadushin, 1962). People generally do not have any contact with a psychotherapist, unlike their usually knowing a physician or clergyman, and, hence, require a referral. Perhaps those who seek a non-mental health source of help do not have access to a referral guiding them to a psychotherapist. This seems unlikely. Each of these people probably has a potential formal referral source to mental health care in the non-mental health agent to whom he/she has brought the presenting problem.

Perhaps the referral source--whether a professional, friend, or relative--not only provides the necessary contact with the mental health profession, but, more importantly, gives the person the opportunity to publicly discuss one's troubles and to raise the possibility of obtaining professional psychological help. The referral source may be supportive and accepting of both the disclosure of personal problems and the possibility of seeking mental health care. Such acceptance and approval may be very critical in reducing the powerful societal stigmatization of seeking mental health care which acts as an obstacle to obtaining such help. This does not mean that the person is coerced or even actively encouraged to seek mental health care, an approach which might be experienced as too directive and threatening to someone's autonomy while struggling with feeling unable

to adequately cope by oneself. Rather, the referral source may simply lend a sympathetic, accepting ear which, by not rejecting the potential mental health help-seeker, may disconfirm his/her worst fears of societal stigmatization.

As Kadushin (1969:252) explains, "The very process of deciding to enter psychotherapy is itself part of the psychotherapy. Since fear of exposure of one's illness or condition is no doubt the crucial deterrant to gaining information about psychotherapy, searching for information about therapy itself helps one to overcome the feelings of shame." While Kadushin highlights the shame involved in discussing one's troubles with another, the interpretation presented here emphasizes the much greater threat involved in simply discussing the possibility of seeking psychotherapy. There is societal tolerance for severe emotional problems as long as they are not labelled as "mental illness" (i.e., by seeing a mental health professional). Thus, it is not so much discussing emotional problems, but what one may do about them--seek psychological help--which is likely to arouse shame and the fear of rejection from being cast as "crazy." Obtaining a referral may, therefore, more importantly involve finding out one can seek help without facing rejection, rather than finding out where to go for help. By talking it over with someone, one has "tested the waters." What is clear is that if one does not talk about the possibility of seeking mental health care with a referral source, it is much more likely that non-

mental health assistance will be sought.

Another important determinant of the decision to seek mental health care is belonging to a mental health reference group. Since this variable is very significantly related to seeking mental health care independent of the referral source and psychological orientation to presenting problem, the importance of belonging to a mental health reference group may not be reduced to the functions of either providing a referral source or structuring the presenting problem in more psychological terms. In fact, other findings provide no evidence to suggest that belonging to a mental health reference group facilitates either a psychological interpretation of the presenting problem or the use of an informal referral.' By eliminating the other major possibilities, it seems likely that belonging to a mental health reference group facilitates the decision to seek mental health care by de-stigmatizing that action. Knowing a close friend or relative who sought psychological help makes it more socially acceptable to seek such help for oneself (Phillips, 1963). In fact, if one belongs to a reference group which strongly endorses using mental health professionals as an approach to coping with emotional problems, seeking mental health care when warranted is viewed as more socially acceptable than not obtaining needed psychological help (Schroder & Ehrlich, 1968).

'These results are based on another analysis comparing members from non-members of a mental health reference group among those seeking mental health care. See Leon (1983) for

It could be argued that due to the retrospective design of the study, belonging to a mental health reference group may represent an outcome rather than a cause of seeking mental health care. If that were the case, it would probably serve the same function, although obviously not as a causal factor in seeking mental health care. One may need to make new affiliations to reduce the cognitive dissonance produced by moving into a role which conflicts with former beliefs and attitudes (Festinger, 1962). Making friends of those who have sought mental health care after one has decided to seek such help may be an important way to enhance the social acceptability of that action. The importance of establishing an informal support group of people with similar experiences to protect stigmatized individuals from societal denigration has been described by families of patients who have been psychiatrically hospitalized (Yarrow, Clausen et al., 1955).

While Kadushin (1966, 1969) also emphasizes the importance of belonging to a psychiatric social circle--the "friends and supporters of psychotherapy"--in the decision to seek mental health care, several distinctions need to be made between his view and the one presented here. He highlights the role of this social circle in specifically seeking psychodynamic therapy, while the importance of a mental health reference group affiliation is associated here with

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further details of that analysis.

seeking any mental health care.'[9] Furthermore, seeking mental health care within his psychiatric social circle seems to represent a positive attraction, while in this conceptualization, belonging to a mental health reference group primarily reduces the societal barriers of stigmatization erected against seeking such help. These interpretations are not necessarily contradictory since the "friends and supporters of psychotherapy" may be a particular sub-group of mental health reference groups, one which is more positively motivated to seek such help than the rest of the mental health help-seeking population.

The decision to seek mental health care is best explained by the socio-cultural perspective in this study. Among those who have decided to seek some kind of formal help, reported distress (i.e., severity and how experienced), one's values, resources, and general psychological orientation are all virtually irrelevant to seeking mental health care.'' Seeking mental health care seems to

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'[9]Kadushin seems to have in mind a much more differentiated classification of a psychiatric social circle than my own rather broad criterion of simply having any association with the mental health profession through knowing a close friend or relative who sought such help.

''The wide range of agents included under the rubric of mental health care may partially be responsible for the surprising lack of association between seeking a mental health consultation and structuring one's distress in more psychological terms. The more psychological manner in which more psychiatrically sophisticated users structure their distress compared to their less psychiatrically astute peers who seek less psychodynamic and briefer forms of psychological help (Kadushin, 1969), may result in the dilution of the association of this factor with all mental health care usage.

depend less on who one is, whether that be defined by reported distress, values or adaptive capacities, than whom one knows. The greater importance of situational over internalized factors in the decision to seek mental health care suggests this help-seeking group does not constitute a fixed, readily identifiable group based on enduring intrapsychic differences. Rather, whether such help is obtained is more a product of one's social contacts, particularly during the help-seeking process. Social network influence seems rooted much less in how cohesively one's reference groups are structured than the content of sub-group norms (i.e., specifically the acceptablility of seeking mental health care in one's reference group). While the importance of the psychiatric sick-role could not be directly evaluated with the independent variables available, the de-stigmatizing and normalizing effects of one's reference group on the meaning of seeking mental health care have been presented as the critical processes mediating social network influence.

Future research needs to more adequately assess the role of stigmatization of seeking mental health care on the decision to obtain a mental health consultation. How does the individual experience the potential for stigmatization both in one's self-appraisal and what it might mean socially should others "find out"? The perception of the psychiatric sick-role by the individual who considers obtaining a mental health consultation must be more clearly delineated--what

restrictions it entails and how long the role is believed to last. The choice of a particular mental health practitioner (i.e., psychiatrist, psychologist, social worker, or guidance counselor) and the setting (i.e., public clinic, private clinic, or private practitioner) may be related to the degree of stigmatization and danger of exposure associated with these different agents and contexts. The specific ways in which perceived stigmatization may be reduced--by knowing someone well who has sought such help or by talking over the possibility of seeking mental health care--must also be examined.

Conclusions

This study highlights the usefulness of psychological variables and models in explaining formal help-seeking for emotional problems and the particular decision to seek mental health care. Multivariate psychological models of seeking formal help and mental health care developed in the total population effectively explain help-seeking behavior in samples stratified by sex, age, and educational level. Considerable differences among formal help-seekers depending upon which agent is chosen reduces the common factors involved in all instances of seeking formal help for emotional problems.

Seeking mental health care as opposed to other kinds of formal help is associated with knowing someone who has obtained such help and using a referral source. It is not

based on the report of debilitating distress in the health belief model or having a more introspective orientation in the ego psychological perspective. In this study, obtaining mental health care is more a product of the help-seeking process than stable, internalized intrapsychic differences. The acceptance, if not active support, of the decision to seek mental health care by one's social network is presented as the critical intervening psychological mechanism of the socio-cultural perspective.

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